LICENSURE APPLICATION ADDENDUM:
FACT SHEET FORM

TENNESSEE DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES OFFICE OF LICENSURE

INSTRUCTIONS: This form is an addendum to the application for license and is to be used to describe the facility/service to be operated at a given site. One (1) fact sheet form is to be completed for each distinct facility/service category to be operated at a given site. This form must be completed when making application for initial license to operate a newly established facility/service. This form is also to be used by any current licensee who is applying for license to operate an additional facility/service, to relocate a currently licensed facility/service to another site or building, to expand an existing facility/service, or to change the distinct facility/service category or occupancy of a currently licensed facility/service.

1. NAME OF APPLICANT:	2. DATE:

3. PURPOSE OF FACT SHEET: Identify the reason for the completion of this fact sheet: (Check one)

- ☐ Initial application by new applicant for license to operate a newly established facility/service. (A completed "Initial Application for License" form must accompany this fact sheet.)
- ☐ Application by a current licensee for license to operate an additional facility/service to be established by current licensee.
- ☐ Application by a current licensee to relocate a currently licensed facility/service to another site or building. (Licenses are non-transferable.)
- ☐ Application by a current licensee for approval of major renovation; change in use or occupancy; or expansion of the physical plant of a currently licensed facility/service. (A new License may be required.)

4. NAME AND LOCATION OF FACILITY/SERVICE. Identify this facility/service as it is to be named by the applicant, known to the public, and listed on the license:

Name		Facility/Service Telephone No./Fax No.
Street And Email Address of Facility/Service		
City/Town	Zip Code	County

Is the location of the facility/service inside of city limits? ☐ YES ☐ NO

5. DISTINCT CATEGORY. Identify the distinct category of this facility/service as defined in the licensure rules: (CHECK ONLY ONE.)

Mental Health
- ☐ Outpatient
- ☐ Adult Day Treatment Services
- ☐ Hospital
- ☐ Adult Residential Treatment Program
- ☐ Crisis Stabilization Unit
- ☐ Supportive Living
- ☐ Psychosocial Rehabilitation Program
- ☐ Intensive Day Treatment for Children & Adolescents
- ☐ Therapeutic Nursery
- ☐ Partial Hospitalization Programs
- ☐ Residential Treatment for Children & Youth
- ☐ Adult Supportive Residential

Alcohol and Drug Abuse
- ☐ DUI School
- ☐ Halfway House Treatment
- ☐ Non-Residential Opiate Treatment
- ☐ Non-Residential Treatment
- ☐ Residential Detoxification Treatment
- ☐ Residential Rehabilitation Treatment
- ☐ Residential Treatment for Children and Youth
- ☐ Outpatient Detoxification Treatment

- ☐ Personal Support Services Agency

6. SITE MANAGER/DIRECTOR. Identify the person who is charged with the overall daily management of this facility/service:

Name of Person:	Title/Position:

Has this person ever been convicted of or currently under any charges of a felony offense under the law? ☐ NO ☐ YES
If yes, attach an explanation of the date, type and place of the charge, court action taken, or current disposition.

NOTE: ITEMS NUMBERED (7) THROUGH (23) DO NOT APPLY TO PERSONAL SUPPORT SERVICES.

7. NUMBER OF BUILDINGS. Identify the number of buildings on the site of this facility which are to be used for service recipient residences or other service recipient programs: ____ . If more than one (1) building is to be used on the site of this facility category, then list each building by its name or location on the site, and give the primary use of each building and the number of service recipients to reside or to be served in each building.

Name/Location of Building	Primary Use of Building	No. of Service Recipients

(If necessary, attach a separate sheet, and check here ❑.)

8. OWNERSHIP OF PREMISES. Identify the ownership of the buildings, premises or real property in which this facility is to be located: (Check One.)

☐ Owned by the applicant free of mortgage. ☐ Owned by the State of Tennessee

☐ Mortgage Lender:
☐ Leased from:
☐ Donated by:

} Name:_____
Address:_____
City & State: _____

9. NUMBER OF SERVICE RECIPIENTS. Indicate the number of service recipients to reside or to be served in this facility: _____. Are any of the service recipient six years of age or younger? ☐ NO ☐ YES

10. SQUARE FOOTAGE. Total occupiable space of facility in square feet:

11. HOURS OF OPERATION. Indicate the normal days and hours of facility's operation:

12. SHARED OCCUPANCY. Are other activities or occupancies to occur in this building(s) which are not under the control of the licensee/applicant? ☐NO ☐ YES If yes, describe:

13. MOBILE, NON-AMBULATORY SERVICE RECIPIENTS. Are mobile, non-ambulatory persons (persons using wheelchairs, walkers, etc.) to be served in this facility? ☐ NO ☐ YES
If yes, are these persons capable of transferring unassisted from a bed or other fixed position into the wheelchair or other mobility device and traversing a predefined means of egress from the facility? ☐ NO ☐ YES

14. SERVICE RECIPIENT SELF-PRESERVATION. Are all of the persons to be served in this facility to be persons who are capable of self-preservation by responding to an emergency signal, including prompting by voice, and following a pre-taught evacuation procedure from the facility? ☐ NO ☐ YES
Any persons with deafness? ☐ NO ☐ YES Any persons with blindness? ☐ NO ☐ YES

15. SECURITY MEASURES. Are security measures, such as exit doors or windows locked against client egress, restraints, or seclusion, which are beyond the client's control to be used in this facility? ☐ NO ☐ YES If yes, explain:

16. VOCATIONAL ACTIVITIES. Are vocational activities to be conducted in this facility? (Activities of an industrial or productive nature such as contract work, assembling, packaging, woodworking, metalworking, painting, stripping, etc.) ☐ NO ☐ YES

17. FOOD SERVICE. Are food service, food preparation, and meals to be provided by this facility on a regular basis to the service recipients of the facility? ☐ NO ☐ YES

18. BATHROOM ACCOMMODATIONS. Number of separate bathtubs or shower stalls: _____ . Number of toilets: _____
Number of urinals: _____. Number of sinks or hand lavatories in bathrooms: _____

19. BUILDING CONSTRUCTION. This facility is to be located in: (check one) ☐ A building to be constructed or under construction.
☐An existing building to be adapted for the facility's use. Number of stories or floors: _____
Basement: ☐ NO ☐ YES Indicate the building's type of construction: ☐ Wood frame with wood, shingle or metal siding.
☐ Wood +frame with Brick Veneer. ☐ Masonry Block, no wood frame members. ☐ Masonry Block with wood frame members.
☐Reinforced concrete with steel members. ☐ Other, describe:

20. WATER/SEWER. Is drinking water furnished by a well/spring located on the property? ☐ NO ☐ YES
Is sewage handled by a septic tank located on the property? ☐NO ☐ YES

NOTE: ITEMS 21 THROUGH 23 ARE TO BE ANSWERED ONLY FOR RESIDENTIAL FACILITIES.

21. LIVE-IN STAFF. Are staff members, proprietors, or family members of the staff or proprietor to reside or have sleeping arrangements in this facility? ☐NO ☐ YES If yes, how many such persons: _____

22. TOTAL OCCUPANCY. Total number of persons including service recipients, staff, family, etc. to reside in this facility: _____

23. NUMBER OF ROOMS. Service recipient bedrooms: _____ Staff or other bedrooms: _____ Living Room: _____
Den: _____ Dining Room: _____ Kitchen: _____ Bathrooms: _____

24. OTHER. Use this space to provide any additional information or to explain any of the above item

_____

_____

_____

_____

_____

IDENTIFICATION OF INFORMATION. The information contained in this fact sheet is an addendum to, or a part of the application for a license. The person signing below must be the individual applicant in the case of a proprietorship or partnership; or the chairperson or equivalent officer of the governing body in the case of a corporation or other association making application; or in the case of a governmental agency or state university, the person charged by the appointing authority with responsibility for the operation of the facility/service.

I HEREBY DECLARE THE INFORMATION CONTAINED IN THIS LICENSURE APPLICATION ADDENDUM TO BE TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I FURTHER DECLARE MY AUTHORITY AND RESPONSIBILITY TO CERTIFY THIS INFORMATION IN MAKING APPLICATION FOR LICENSE TO CONDUCT THE FACILITY DESCRIBED HEREIN. I AGREE TO COMPLY WITH THE RULES PROMULGATED FOR THE OPERATION OF THIS FACILITY/SERVICE UNDER TENNESSEE CODE ANNOTATED TITLE 33, CHAPTER 2, PART 4.

SIGNATURE OF APPLICANT OR AUTHORIZED AGENT:	DATE OF SIGNATURE:

Type or Print Name and Title of Person Signing Above:

FOR TDMHASAS OFFICE USE ONLY-DO NOT WRITE IN SPACE BELOW

LICENSURE REVIEW AND APPROVAL STATUS:

☐ NO LICENSURE GRANTED Reason:

☐ LICENSURE GRANTED

License Type: ☐ Initial ☐ Full ☐ Provisional

Effective Date:

Expiration Date:

Service Type: ☐ MH ☐ A&D ☐ PSSA

Distinct Category:

Life Safety Occupancy Classification:

Approved for Mobile, Non-Ambulatory Individuals? ☐ No ☐ Yes

Service Recipient / Bed Capacity:

Approved for Individuals With Hearing Loss? ☐ No ☐ Yes

Approved for Individuals With Vision Loss? ☐ No ☐ Yes

Other Special Conditions Stated on License:

FINAL REVIEW AND APPROVAL STATUS COMPLETED BY:

Clear Form

	Other Special Conditions Stated on License:
FINAL REVIEW AND APPROVAL STATUS COMPLETED BY:	